IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 002 7979 088

December 3, 2010

Cliff McAleer, Administrator
Milestone Decisions Inc #3 Lexington
611 South Main
Moscow, ID 83843

RE: Milestone Decisions Inc #3 Lexington, Provider #13G044

Dear Mr. McAleer:

Based on the Medicaid/Licensure survey completed at Milestone Decisions Inc #3 Lexington on November 18, 2010, we have determined that Milestone Decisions Inc #3 Lexington is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on **Client Behavior & Facility Practices (42 CFR 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Milestone Decisions Inc #3 Lexington to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed.

Sign and date the form(s) in the space provided at the bottom of the first page.

Such corrections must be achieved and compliance verified by this office, before January 2, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 25, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **December 16, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Milestone Decisions Inc #3 Lexington ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective November 18, 2010, through March 18, 2011. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **December 29, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 14, 2010. If a request for informal dispute resolution is received after December 14, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

M. Nielsen

MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srm
Enclosures

12-15-10

Credible Allegation of Compliance
Plan of Correction

Bureau of Faculty Standards
3232 Elder St.
Boise, ID 83720

RE: Milestone Decisions, Inc. #Provider #13G044

Dear Survey Team,

This is out Credible Allegation of Compliance Plan of Correction for the Milestone Decisions, Inc. #3 Provider #13G044. We will be in compliance with the Condition of Participation on Client Behavior and Facility Practices (42CFR483.450) on December 22, 2010. Please refer to the following plan of correction which outlines how the correction of each deficiency will be achieved

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G044	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS INC #3 LEXINGTON	2087 LEXINGTON AVENUE MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Trish O'Hara, RN Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: CFA - Comprehensive Functional Assessment IDT - Interdisciplinary team IPP - Individual Program Plan OT - Occupational Therapist QMRP - Qualified Mental Retardation Professional ROM - Range of Motion VNS - Vagal Nerve Stimulator WIC - Written Informed Consent	W 000		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all information was kept confidential for 2 of 2 individuals (Individuals #2 and #4) whose full names were noted to be posted in the dining room and living room of the facility. This resulted in individuals' information being available to other individuals, visitors, and non-staff. The findings include: 1. During an observation on 11/16/10 at 2:10	W 112	Refer to plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Cliff McAlear Administrator 12-15-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G044	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS INC #3 LEXINGTON	2087 LEXINGTON AVENUE MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	Refer to Plan of Correction	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W313.	MM191		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive	MM212		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE CL McAfee TITLE Administrator (X6) DATE 12-15

STATE FORM 6899 IQB211 If continuation sheet 1 of 5

PLAN OF CORRECTION
#13G044

W112-

The faculty has ensured individuals #2 and #4's information is kept confidential by removing the postings in the dining room and the living room. An inspection of the home has been completed to ensure that all other individuals information in the home is being kept confidential. Staff training on confidentiality will be scheduled for all staff in the home. House Administrator/QMRP and Lead Worker will monitor by regular observation on a day to day basis.

Date completed: 1-15-11

W124

Individual # 1's WIC will be revised to ensure it contains accurate information on which to base consent decisions. WIC's for all other individuals in the home will be reviewed and compared to behavior programs to ensure they contain accurate information. Additional staff training on behavior program implementation including providing sufficient information on the WIC, will be provided. Treatment team and HRC will monitor by review of behavior programs and corresponding WIC's.

Completion Date: 12-22-10

W159- Refer to; W112, W124, W214, W224, W227, W237, W239, W242, W260, W313, W436, W488

W214

Behavior Assessments will be completed for those individuals found to have been affected by the deficient practice. Comprehensive Functional Assessments will be reviewed for all individuals at the home to determine if a behavioral assessment is needed. The Comprehensive Functional Assessment will be revised to identify those individuals in need of a behavioral assessment. In addition a new behavioral assessment has been created and will be completed for all individuals identified in the CFA to be in need of a behavioral assessment. A category for the behavioral assessment will be added to the IPP checklist, reviewed by the Administrator, to ensure the deficient practice will not recur.

Date Completed: 12-22-10

W224

Individual #2's CFA will be completely redone to ensure it is accurate and reflective of his current functional status. The CFA's for all other individuals in the home having the potential to be affected by the same deficient practice will be reviewed for accuracy and revised as necessary. To ensure the deficient practice does not recur a review of each completed CFA by a team consisting of the House Administrator/ QMRP, the lead worker and at least one direct care staff will take place. The team review will be documented on the IPP checklist and monitored by the facility Administrator who will review the checklist.

Also refer to W 242.

Date Completed: 2-1-11

W227- refer to W 214 as it relates to meeting the behavioral needs for individuals #1 and #2 and all individuals in the home having the potential to be affected by the deficient practice. All assessments and recommendations, for the individuals affected by the deficient practice and all individuals potentially affected, will be included in the CFA. A category will be added to the IPP checklist, reviewed by the Administrator, to ensure the deficient practice does not recur.

Date Completed: 12-22-10

W237

A new data collection system will be implemented for those individuals found to be affected by the deficient practice and for all individuals in the home potentially affected by the deficient practice. The new data collection system will provide the additional information necessary to determine the efficiency of individuals behavior intervention strategies. The House Administrator/QMRP and the Lead Worker will monitor data collection by reviewing weekly.

Date completed: 12-22-10

W239

Replacement plans will be developed for all maladaptive behaviors identified in the behavior assessment (refer to W214) for the individuals found to have been affected by the deficient practice and for all individuals in the home who have the potential to be affected. The new behavior assessments is structured to ensure each identified maladaptive behavior has a corresponding replacement behavior. This will be monitored on the IPP checklist which will list maladaptive behaviors and replacement plans.

Completed by: Dec 22, 2010

W242

The CFA's will be reviewed for the individuals found to be affected by the deficient practice and for other individuals in the home having the potential to be affected, to ensure training in personal skills essential for privacy and independence, for those who lack them will be included in their IPP. During review, a checklist of the personal skills outlined in W-242 will be completed and compared to IPP to ensure the deficient practice will not recur. The personal skills list will be added to the IPP checklist, which will be reviewed by the Administrator, to monitor and to ensure the deficient practice will not recur.

Completed by: Feb 1, 2011.

W266- Refer to W-124, W-214, W-227, W-237, W-239, W-313

W313

For the individual found to have been affected by the deficient practice, the facility will do a record review to determine if the harmful effects of the behavior outweigh the associated risks of the drugs. The treatment team will meet to assess the documentation and agree on a course of action. For all other individuals having the potential to be affected by the defiant practice a record review will be conducted and a treatment team assessment will take place. Refer to W 214 and W 237 as new measures put place and support the teams decision. This will be monitored by review at HRC meeting.

Completed by: 12-22-10

W436

Individuals #2 and #4's wheelchairs are scheduled for repair. All individuals adaptive equipment will be inspected to ensure it is good repair. An individual checklist of all adaptive equipment for all individuals in the home will be generated and filled out monthly indicating if the equipment is in need of repair. In addition, a maintenance request form for adaptive equipment will be made available for staff to request immediate repair. House Administrator/QMRP and Lead Worker will monitor by review of checklist and maintenance requests.

Completion Date: 1-24-11

MM 164- refer to W 124

MM 191- Refer to W 313

MM 212-Refer to W242 and W 266

MM 412-

Repairs or replacement of all noted items have been scheduled. An inspection of the entire environment has been scheduled with the maintenance Dept. to determine if there are any other repairs necessary. Maintenance will do a monthly inspection to ensure the environment is in good repair. House Administrator/QMRP will monitor by reviewing checklist and scheduling repairs.

Completed: 2-01-11

MM 429- Refer to W 436

MM 575- Refer to W112

MM 724- Refer to W 224 and W 227

MM 725- Refer to W 159

MM 730- Refer to W 214

MM 731- Refer to W 237

MM 812- Refer to W 239